as surgeons can cure 85 per cent of his failures, there seems to be no good reason for rivalry.

Granting the possibility of healing, contraction may follow with hour-glass stomach, and frequently, stenosis, especially about the pylorus, with still the possibility of the recurrence of ulcer in the scar tissue.

Here, as in the duodenum, perforation, of course, requires immediate surgical interference. The question of excision of the gastric ulcer, followed by gastroenterostomy, is still a debatable one. Most experienced surgeons believe that gastroenterostomy should be done. If ulcer is to be considered potentially carcinoma, excision would seem to be the better surgical judgment. Whether this should be immediately followed by gastroenterostomy must depend a great deal upon the judgment of the surgeon.

SUMMARY

After our many years of experience, made up of successes, errors and disappointments, we have come to the following conclusions regarding the care of patients with suspected ulcer.

1. Routine assignment to the medical service.
2. Proper differentiation between gastric and duodenal ulcers.
3. To recognize the medical and surgical types.
4. That all gastric ulcers are essentially surgical.
5. That lues must be recognized as one of the causative agents of ulcer.
6. That clinical evidence alone is not sufficient reason for surgical interference.
7. That the surgeon must ever keep in mind the part that focal infection plays. He should possess sufficient acumen to attribute to these various factors their proper place in disurbance of digestion.
8. The general practitioner, who occasionally practices operating, should keep his hands out of the upper abdomen, as he lacks the judgment only gained by long practice of surgery.
9. That the responsibility for operation rests heavily upon the roentgenologist for a possible error in non-surgical cases.
10. That surgery does not relieve the patient from the necessity for medical care following gastroenterostomy.
11. That many of the troubles encountered by the patient and many of the reflections cast upon the surgeon are due to lack of supervision and advice, following the mechanical work of surgery.
12. That many so-called medical cures of duodenal ulcer are of doubtful diagnosis, and when sufficient evidence for diagnosis is presented, clinically and by X-ray, the case is well on its way to the hand of the surgeon.

Medical Building.

Phi Rho Sigma—The members of this national medical fraternity with some thirty chapters in different states will hold a banquet at the St. Francis Hotel, Wednesday evening, June 27, at six-thirty o'clock. After the banquet the members will attend the reception to the President of the American Medical Association, at the Fairmont Hotel. Phi Rho Sigmas are requested to communicate with Charles S. French, 749 Flood building, San Francisco.

OSTEITIS FIBROSA CYSTICA OCCURRING IN A FLAT BONE

Report of a Case

By A. H. GALVIN, M. D.
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Our knowledge of cyst formation in the long bones dates back to 1876, when Virchow described a cyst of the humerus which he considered as being due to a liquefaction of a chondroma. Following this article there appeared one by Rindfleisch in 1886, and Hirschberg in 1889, in which they both described cysts, occurring in cases of osteomalacia. It was not, however, until 1891 that Von Recklinghausen described in detail general osteitis fibrosa cystica of the long bones, and to which his name has since been attached. From this time on, various authors have published articles and described their findings in more or less detail, both in Europe and America. Chief among American authors have been Bloodgood, Beck, Silver, Freiberg, Murphy, Percy, and Meyerding. Up to 1911, the most comprehensive work that appeared was one by Silver, in which he reviewed the subject to date, together with a bibliography. In 1918, Meyerding reported a series of nineteen cases from the Mayo Clinic. This series was not confined to single bone cysts, but included multiple cysts as well. His conclusions were similar to those arrived at by Silver. Silver in his paper says:

"The term bone cyst is used today in a more or less specific sense to designate those cases in which the formation within the bone of a cavity filled with fluid is the most prominent symptom and in which examination of the surrounding tissues and of the fluid fails to reveal any readily apparent connection with a definite disease."

Confining himself to the above definition of bone cysts, and excluding such cases arising from softening of pre-existing tumors, cysts due to infection (the so-called bone abscess), cysts due to parasites, those occurring in rarefying bone disease, those found in general osteitis fibrosa, callous cysts, and cysts in Barlow's disease, he was able to find one hundred and four cases which conformed to this definition, and from these he excluded seven, because more than one cyst was present.

The distribution of the remaining ninety-seven cases was as follows:

Femur	31	Phalanges	7
Tibia	15	Astragalus	1
Fibula	6	Calcaneus	2
Humerus	25	Metatarsal	1
Ulna	2	Clavicle	3
Radius	1	Pelvis	1
Carpal Scaphoid	1	Metacarpal	1

His table shows that the majority of cases of cyst appear in the long bones, and in these the femur and humerus show the highest percentages. Since the disease shows a predilection for the long bones, and the femur and humerus in particular, the following case occurring in a flat bone, and no other case having been found in the literature, the writer feels that it is worthy of being reported in detail.

Case No. 7431—E. B. M., aged 23, male, born in Michigan, occupation, oil worker, single.


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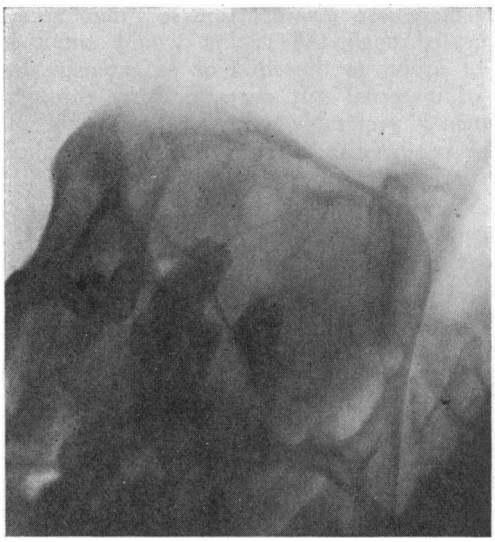

PLATE No. 1.
This shows quite clearly the cyst of the multilocular type, likewise the fourth molar within the cyst cavity, before operation.

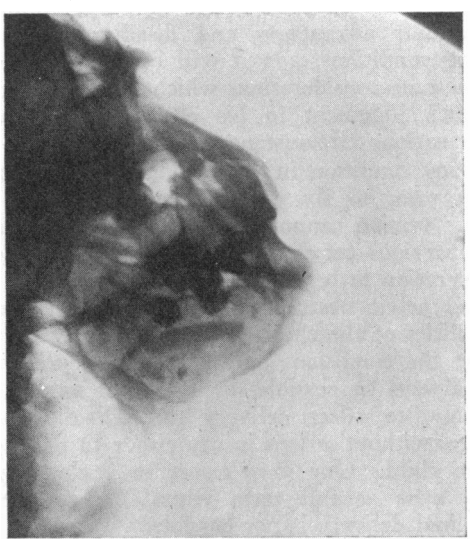

PLATE No. 2.
Shows the transplant with beginning osteogenesis at the posterior end of graft.

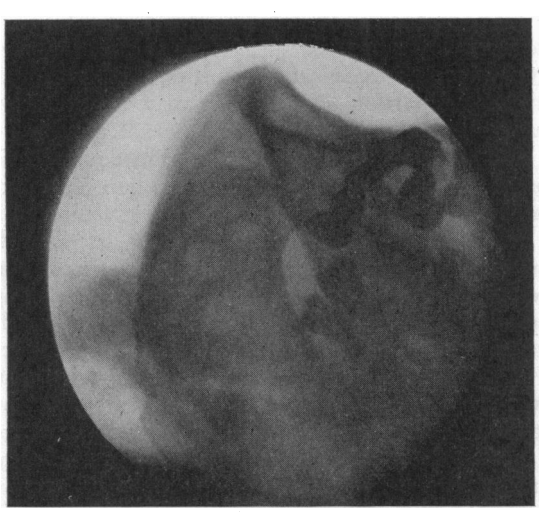

PLATE No. 3.
Showing complete absorption of transplant and cavity filled with new bone.

Family history and previous history are not important; denies venereal.

Present Illness—Two and a half years ago while scuffling with a friend he received a rather hard blow on the left lower jaw, no immediate trouble was experienced except that the jaw would drop when in certain positions. There was no pain at this time. One year later the jaw began to swell, and he had some slight soreness, but no actual pain. For the past two months he thinks the tumor has grown more rapidly.

Physical Examination—Well developed and nourished. Eyes and ears, negative. Heart, lungs and abdomen, negative. No paralysis, and reflexes normal. In the region of the angle of the left jaw is a hard tumor mass measuring 5 x 3½ cm., neither red nor tender. This tumor extends forward to the mental foramen, and upward to about the middle of the ramus. There is no pyorrhoea and the teeth are in good condition, with some crowns on the front upper incisors. The motions of the jaw are not restricted, no glandular enlargement. Blood pressure, 120/80. Blood, Hbg., 98 per cent; red cells, 4,720,000; leucocytes, 11,600; with a normal differential count. Wasserman, negative. Urine, negative; no Bence Jones bodies found. The roentgenograms showed a cystic formation in the bone in which could be seen an inverted third molar.

Operation—The cortex of the bone over the tumor was very thin and broke down after the skin was incised. The cavity was found filled with a brown serous fluid. It was explored, all the cysts were broken down and a transplant from the tibia inserted, reaching from the angle of the jaw to the anterior border of the cyst wall. The wound healed by first intention. Two months later he complained of some pain in his mouth with bleeding around the third molar. He was referred to the dentist, who found the tooth extremely tender, and it was accordingly extracted with immediate relief of pain.

At the present time he has no pain, no restriction of motion, and the cortex of the bone over the original tumor is firm. He has resumed his work in the oil fields and feels perfectly well. The photograph and X-ray prints show the condition before and after operation. The last roentgenogram shows that the transplant is absorbed.

The Advertising Pages—We believe that the advertising columns of a medical journal should be something more than a mere marketing place, where every Tom, Dick, and Harry who has something to sell may cry his wares, provided he has the price of the space, and where the crowd may jostle one another, each looking out for himself, and making his bargain with the seller on the old common-law principle of caveat emptor. It is our conviction that the advertising pages should be on the same plane with the rest of the journal: i. e., that they should serve the real interests of the readers; that, in perusing these pages, the reader may, in effect, walk through an exposition or exhibit of the picked products of the medical and surgical industries, where he may view the best and most approved remedies, appliances, and other armamentaria, which inventive ingenuity and manufacturing skill have devised for his assistance.

A medical journal is primarily for the benefit of the man in the field, who, in the last report, is the man that wages and wins the war against disease and death. Interesting and valuable, in their place, as the processes may be by which the armaments of warfare are worked out, the important thing to the man on the firing line is that he be furnished with efficient weapons, ready to use. By the same token, the all-important need of the medical practitioner is to be kept in constant touch with what is being prepared for him in all parts of the world, and furnished with practical, up-to-the-minute weapons, which he can utilize in his practice.—The Medical Standard, April, 1923.